California Newborn Hearing Screening Program

[Enter Hospital Name Here]

NEWBORN HEARING SCREENING
Infant Reporting Form

INPATIENT SCREEN COMPLETED

IP Screening	RIGHT EAR		LEFT EAR	
DATE OF SCREENING				
TYPE OF SCREENING *(check one)*	☐ ABR ☐ DPOAE ☐ TEOAE	☐ ABR ☐ DPOAE ☐ TEOAE	☐ ABR ☐ DPOAE ☐ TEOAE	☐ ABR ☐ DPOAE ☐ TEOAE
RESULT *(check one)*	☐ PASS ☐ REFER	☐ PASS ☐ REFER	☐ PASS ☐ REFER	☐ PASS ☐ REFER

INPATIENT SCREEN NOT DONE (*fax completed form to HCC*)

☐ Transferred out to: _____ Hospital on (*date*):_____

☐ Missed; discharged without screen ***(complete Follow-Up section below)***

☐ Waived (Face Sheet not required) - ☐ NHSP Brochure given to parent

☐ Expired on: _____ (date)

☐ Physician determined screening not medically indicated. (Face Sheet not required)

☐ Baby has Atresia- ☐ Bilateral ☐ Unilateral: ☐ **right** ☐ **left** (*check one) (complete Follow-Up section below)*

FOLLOW-UP FOR REFERS/MISSED *(fax completed form to HCC)*

☐ Parent/Legal Guardian information on face sheet verified/updated

Primary Language (Check One): ☐ English ☐ Spanish ☐ Other: _____

☐ Secondary contact information is verified on face sheet. If not, complete the following:

Second Contact Name **(OTHER THAN PARENT):**_____

Home Phone: _____ Cell Phone: _____ Work Phone; _____

Address: _____

City / Zip: _____

Primary Language (Check One): ☐ English ☐ Spanish ☐ Other: _____

☐ Print Infant's Full/Legal Name:_____

☐ NHSP Brochure given to parent (Circle One): ☐ Pass ☐ Refer ☐ Refer to DX

☐ Follow-Up Appointment made and written on Parent brochure:

APPOINTMENT: ☐ **OP SCREENING** ☐ **DX EVALUATION** FOR NICU PATIENTS OR INFANTS WITH ATRESIA

DATE: _____ **TIME:** _____ ☐ **CCS Referral Made - County:** _____

☐ **Early Start Referral Made**

PROVIDER: _____ **Phone:** _____

☐ PCP, Clinic or Medical Group who will see the Infant after discharge

Full Name: _____ Phone: _____

☐ Completed form faxed with hospital face sheet to the South-Eastern California Hearing Coordination Center (HCC) at Fax No. 909-558-3483. HCC Contact Phone No. 909-558-3478.

PATIENT NAME:_____ ***Addressograph***

Birth Date: _____

☐ **WBN** ☐ **NICU** - Name of Birth Hospital if different

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